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HOME HEALTH AIDE TRAINING PROJECT. FINAL REPORT.

NEW HAVEN VISITING NURSE ASSN., CONN.
GREATER NEW HAVEN COMMUNITY COUNCIL, CONN.

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THE HOME HEALTH AIDE PERFORMS SIMPLE PERSONAL CARE FUNCTIONS UNDER NURSING SUPERVISION IN THE HOME CARE OF AN ILL OR DISABLED PERSON. THE PROJECT OBJECTIVES WERE TO TRAIN AS AIDES 30 MEN AND WOMEN AGE 45 YEARS AND OLDER WITH LIMITED INCOMES TO MEET A COMMUNITY EMPLOYMENT NEED AND TO EXPERIMENT IN RECRUITMENT, SELECTION, TRAINING, AND EMPLOYMENT PROCEDURES. RECRUITMENT AND INITIAL SCREENING WERE HANDLED BY THE NEIGHBORHOOD EMPLOYMENT CENTERS, AND FINAL DECISIONS WERE MADE BY THE PROJECT DIRECTOR. THIRTY APPLICANTS WERE ACCEPTED IN TWO GROUPS. FOUR WEEKS OF PRE-SERVICE TRAINING AIMED AT DEVELOPING NEEDED SKILLS. DURING A 2-WEEK ON-THE-JOB TRAINING PERIOD, THE AIDES WERE ASSIGNED TO CAREFULLY SELECTED PATIENT CARE SITUATIONS IN WHICH, UNDER SUPERVISION, THEY DEMONSTRATED THEIR ABILITIES TO GIVE PERSONAL CARE. ON THE 5TH DAY OF EACH WEEK THEY RETURNED TO THE TRAINING FACILITY TO DISCUSS THEIR EXPERIENCES AND REVIEW PROCEDURES. THE 14- TO 16-WEEK INTERNSHIP MARKED THE BEGINNING OF FORMAL EMPLOYMENT AND, DURING THIS PERIOD, A GROUP CONFERENCE, LED BY THE PROJECT DIRECTOR , WAS HELD 1 AFTERNOON A WEEK. TRAINEES WERE PAID $1.40 PER HOUR DURING THE FIRST AND SECOND PERIODS AND $1.50 DURING THE INTERNSHIP. OF THE 30 TRAINEES, 27 COMPLETED THE INTERNSHIP, AND 23 WERE EMPLOYED IN TRAINING-RELATED WORK AT THE TIME OF THE REPORT. A DESCRIPTION OF THE HOME HEALTH AIDE SERVICE OF THE VISITING NURSE ASSOCIATION AND A LIST OF PERSONAL CARE PROCEDURES ARE INCLUDED. (JK)

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FINAL REPORT

OF A

HOME HEALTH AIDE TRAINING PROJECT

ADMINISTERED BY

THE VISITING NURSE ASSOCIATION OF NEW HAVEN, Conn.

UNDER AN

OFFICE OF ECONOMIC OPPORTUNITY GRANT

(PROJECT #C.G. 66-8366)

1966-1967

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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*Carried out in cooperation with:

The Community Council of Greater New Haven.

Community Progress, Inc., New Haven, Conn.

THE VISITING NURSE ASSOCIATION OF NEW HAVEN

FINAL REPORT OF A

HOME HEALTH AIDE TRAINING PROJECT - C.G. 66-8366

NEED FOR A HOME HEALTH AIDE SERVICE

Home health care of the chronically ill, the aged, infirm, and convalescent has been recognized as a rapidly growing need. According to the U.S. Census Bureau statistics for 1965, there were 18.2 million Americans 65 years of age and older, about six times the number in 1900. Since 1900 the total American population has increased only two and one-half times, from 76 to 196 million.

The Visiting Nurse Association of New Haven experienced a rapid growth in the numbers and frequency of visits to elderly ill patients from 1962 through 1965. During this three year period, home visits to ill patients 65 years old and over increased from 4,991 to 9,475 for a net gain of 88.3%. While elderly patients accounted for 35% of the total active caseload of ill patients receiving care in 1965, they received 61% of the total visits. This bears out the fact that older people require more frequent care and care over longer periods of time. Care is needed because of their chronic as well as acute conditions and the aging process in general.

A survey of the 232 patients 65 years of age and older in the active New Haven VNA caseload indicated that 25.8% (60) had definite need for the services of a home health aide in addition to professional public health nursing service. The experience of other home health agencies in the Greater New Haven area reflected a proportionate need and desire for home health aide assistance as part of an ongoing home health treatment program.

Public health nurses observed and stated that especially among the elderly certain patient needs which could normally be met if a capable family member were present in the home were not fulfilled. It was felt that these needs could be met quite effectively through the provision of home health aide service as part of the home health care team. The home health aide service would include simple, personal care functions by workers under nursing supervision in homes where there is an ill or disabled person.

PROPOSAL FOR ACTION

In view of this need for a home health aide service the Visiting Nurse Association of New Haven and the Community Council of Greater New Haven submitted a proposal on June 1, 1966 to the Office of Economic Opportunity through Community Progress, Inc., New Haven, Connecticut, to recruit, select, train, and employ thirty home health aides with appropriate evaluation as part of a one year demonstration program. The proposal was submitted under Section 207 of the Office of Economic Opportunity Act of 1964.

The specific objectives of the project as outlined in the proposal were as follows:

1. To offer training and employment opportunities for thirty men and women age 45 years and older with limited incomes.

2. To meet a specific and well documented need for home health aide service in the Greater New Haven Community.

3. To experiment with new methods in the recruitment, selection, training, and employment of home health aides in the face of critical manpower shortages in the health and allied career fields.

4. To provide career advancement opportunities to trained aides.

5. To provide for appropriate referral and counseling of candidates disqualified by medical, intelligence, or other reasons.

The project outlined a training program in two sessions; each session was to involve fifteen trainees and was to run approximately twenty-two weeks.

On July 14, 1966 Community Progress, Inc. was notified by the Office of Economic Opportunity of the approval for the Home Health Aide Training Project.

PROJECT DEVELOPMENT AND RESULTS

Immediately upon notification of the grant award, recruitment for project staff was undertaken. By late August a project director had been appointed. This staff person was assigned to attend the trainer's conference in St. Louis, Missouri, on August 30, and September 1 and 2, 1966. Upon her return recruitment activities for trainees were undertaken, and the training apartment and office was set up. A target date, October 3, 1966, was set to begin the first of the two training sessions for a group of fifteen trainees. Recruitment of the trainees was somewhat slow and resulted in moving the target date forward to October 10, 1966.

During the week of October 3rd, the original project director decided to terminate her appointment. With appropriate notification to the O.E.O. and others involved project activities were suspended pending recruitment and appointment of the new project director.

A new director was recruited, and she began full-time project work on October 31, 1966. Following this appointment basic project training activities proceeded as follows:

	Pre-Service Training (4 weeks)	On-The-Job Training (2 weeks)	"Graduation"	Internship (14-16 wks.)
Group I 15 trainees	11/21/66-12/16/66	12/19/66-12/30/66	12/30/66	1/3/67-4/27/67
Group II 15 trainees	3/20/67-4/14/67	4/17/67-4/28/67	4/28/67	5/1/67-7/26/67

Thirty trainees who met the O.E.O. requirements for age and income entered the training program. Twenty-eight completed the first six weeks of training successfully and were "graduated." During the pre-service and on-the-job training phase, one trainee from Group I did not make sufficient progress to merit continuation into the internship phase. She was referred to a local C.A.P. skill center for further counseling and job training. During the on-the-job training phase, one trainee from Group II dropped out of training of her own volition feeling that she was not emo-

tionally suited for health aide work.

The status of the twenty-eight trainees who completed the initial six weeks of training is as follows:

1. Completed internship phase - 27

   a. currently employeed by Homemaker Services Bureau of Greater New Haven as homemaker, home health aide - 18

   b. currently employed by Visiting Nurse Association of New Haven as public health aide - 3

   c. currently employed by Hamden Public Health and Visiting Nurse Association as home health aide - 2

   d. moved to another state after initial period of employment as home health aide - 1

   e. resigned to take on other work after initial period of employment as home health aide - 2

   f. discharged for inappropriate conduct after period of employment - 1.

2. Discontinued during internship phase - 1

   a. resigned after six weeks of beginning employment with Homemaker Services Bureau - 1.

PROJECT ACTIVITIES AND EVALUATION

The following sections of this report contain information about the way the project was developed and implemented. Included in each section is a factual accounting of procedures and activities, an attempt at evaluation, and additional comments or observation.

A. Recruitment

1. Procedures

The goal of the project was to offer employment opportunities to thirty men and women who were forty-five years of age and older and who had limited incomes. The services of the community action agency, through its Neighborhood Employment Centers, Neighborhood Workers, and Manpower Division staff were fully utilized in the recruitment of potential home health aides.

Initial screening of applicants for age, income, and general suitability was conducted by the five Neighborhood Employment Centers in the city of New Haven. All candidates were given a simple screening test, the General Aptitude Test Battery (GATB), at the employment center. The standard Manpower Interview Guide was filled out for each applicant and a copy sent to the home health aide training project. Following the initial screening and testing, acceptable applicants were referred to the project director for further interviewing. The project director made the final decision as to

the acceptance or rejection of the prospective trainee. Those trainees accepted were then referred for a medical examination, chest x-ray, and serology test before final acceptance into the program was confirmed.

The Neighborhood Employment Centers, through their awareness of persons needing employment, their familiarity with persons in their neighborhoods, their convenient locations, and their experience with interviewing were ideal for recruitment. Newspaper publicity was extremely helpful resulting in community awareness of this training opportunity and in producing interested recruits. Staff of the local and state welfare departments also identified appropriate candidates for the program.

2. Evaluation of Recruitment Procedures

It is believed that the initial screening done by the Neighborhood Employment Centers was extremely helpful in directing the most appropriate candidates to the training program. Because the final interview was the responsibility of the project director, it is felt that no appropriate candidates were discouraged by the Neighborhood Employment Centers. Only those recruits who were obviously ineligible, usually because of age or income, were not referred, and any recruits that were interested, even though their suitability might have been somewhat in question, were referred to the project director for final decision. Thirty of the fifty-six applicants referred by the Neighborhood Employment Centers to the project were chosen. Therefore, approximately one out of three applicants was rejected, and these were rejected for very apparent reasons, usually physical or income ineligibility. Recruits ineligible because of physical condition or limitations were offered counseling with follow up done by the project director. All rejected applicants were referred back to the Neighborhood Employment Centers for assistance in job placement or enrollment in other training. The Neighborhood Employment Center was notified so that they could follow up and counsel the applicant or refer her elsewhere as indicated.

A problem of time delay was encountered. A considerable amount of time elapsed from the initial interview of the candidate at the Neighborhood Employment Center until the referral was received by the home health aide training project. One major reason for this was the time consumed in scheduling a prospective trainee for orientation to the GATB test, scheduling the test, having the test evaluated, and writing a report before the application could be forwarded. The value of this particular test is open to question considering the time consumed, the candidate's concern about taking the test, the variation in interpretation of testing results, the number of candidates who performed below their ability due to fear and a lack of experience in testing, and because it provided no testing of the applicant's ability to write. It would seem that a very simple test which would give an indication of the applicant's general intelligence, ability to write, and ability to follow simple directions would be of greater value. It is highly recommended that other testing methods be investigated or devised. A less complicated test given at the training apartment at the time of interview by the project director would have sufficed and would have eliminated to a large extent the delay in getting applications to the project.

The other factor responsible for a delay in appropriate referrals was one of communication among people involved at the five different centers of recruitment. The numbers of people involved, a change in the project director, and changes in the starting dates of the first training session result

ed in some confusion and a lack of understanding among the personnel involved. Once this problem was identified, a tour of all Neighborhood Employment Centers was arranged for the new project director. This greatly facilitated future communication by clarifying what was needed for the Neighborhood Employment Centers, and by identifying for the project director the appropriate personnel to be contacted at the employment centers.

There were no men applicants for this training project. Any who had applied would have been given consideration for training. However, in view of the limited training facilities it would have been complicated to have had a man in the program. With time allotted for a male trainee to have separate practice in personal care procedures, and with an established caseload of appropriate patients needing home health aide service, it would be very feasible and worthwhile to train a man. It would seem advisable to not train men in a first training session but to include them in sessions as the instructor and program progressed through experience.

The candidates recruited and trained in this project were in the following age groups:

Age	Number of Trainees
45-50	11
51-55	6
56-60	8
61-65	2
66-70	3

One Italian speaking candidate was recruited and trained in the program. She has proved to be extremely successful in working with elderly Italian people many of whom do not speak English.

In summary, the time saved by having the Neighborhood Employment Center do the initial screening and the advantages of their locations and contacts were worthwhile. It is felt that this procedure resulted in all appropriate candidates being directed to the project. Although some form of simple testing would be of value, experience with the GATB test suggests that a search be made for a less complex test. When a change of project administration occurred, regardless of the many time commitments, a personal contact with the recruiting staffs should have been initiated at an early point to facilitate communication.

B. Selection Process

1. Process

The final interview held by the project director was the ultimate basis for selection of trainees for the Home Health Aide Training Project. Once eligibility was verified as to age and income, it was necessary to assess the emotional and mental maturity of the candidate and the individual's interest in and sympathetic attitude toward caring for the sick at home. The original interview held at the Neighborhood Employment Center usually gave some indication of these qualities. At times a telephone contact with the Neighborhood Employment Center interviewer provided additional assistance in understanding the candidate. In certain situations the nurse

instructor was also available to interview and to add her evaluation of the appropriateness of a candidate. With potential trainees who were considered from the Basic Education Program of the Skill Center, a joint conference between the project director and the Skill Center Director was very helpful. When it could be arranged, interviewing and/or evaluation of the candidate's potential by more than one person proved to be desirable.

All candidates were interviewed as soon as their applications were received by the project, and a decision was made as soon as possible in relation to their eligibility for training. There was no attempt to select the best candidates out of a maximum number of applications. There were two reasons for this. One was the objective of this project, to demonstrate whether or not it was feasible to train the really "hard core poor" for a new role in the area of health service. The other was the time element involved, whereby, it was essential to accept candidates who met the minimum requirements as rapidly as possible in order to obtain the fifteen trainees the project grant stipulated would be trained in each session. While it may not be possible in four weeks time to see change in a trainee's behavior and ways of reacting, an attempt was made to develop some self awareness with the hope of lessening the effects of obvious objectionable personality traits or habits. However, there is no question that had it been possible to select from a larger group and on a more competitive basis the calibre of the home health aide might have been higher even though the candidates still were basically from the poverty group.

The project director's final interview was used to establish the candidate's qualifications and to interpret the program to her. It was used also as the first means of establishing rapport between the director and trainee and "setting the stage" for the training experience. Differences in racial and environmental backgrounds of trainees and recipients of service were openly discussed at this time with each individual trainee. This seemed to be an important factor in the readiness with which the trainees adapted to each other.

2. Evaluation of Selection

Interviews, preferably done by two qualified people, at least one of whom must be very familiar with the role of the homemaker-home health aide, are the essential factors in the selection of the trainees. The interview should also serve purposes beyond selection, i.e., orientation to the training being undertaken. Selections made from a large number of applicants might have resulted in a higher quality home health aide graduate. This would have required a longer period for recruitment, and it might not have adequately demonstrated the extent to which the target group could be trained.

3. Comments and Observations on Selection and Ultimate Outcome of Selections Made for this Project

The trainees, both negro and white, varied from well-groomed, fairly articulate and socially experienced women to those from hard core poverty situations with extremely limited backgrounds. It was interesting to note the extent to which the individuals became a group with strong group identity. There was little breaking up into small sub groups according to ethnic or social background. They functioned as a total group in discussions, in practice sessions, and in other activities in the training apart-

ment. The backgrounds and experiences of the varying members of the group were used in discussions to prepare them for the varied home situations they would encounter. Also of interest was the way in which they helped each other. Typical comments were: "Mary, wake up", "Jane, we don't want to hear that story again!", "Ethel, how did you get that spot on your dress?" Considerable personal development was apparent during the four weeks of pre-service training. This training program can be considered successful and worthwhile even without considering its other objectives when one notes the widow who learned to talk and think about something other than her deceased husband, or the mother on welfare who was able to become self sufficient again.

Trainees selected on the basis of meeting the Office of Economic Opportunity eligibility requirements required extensive counseling in relation to personal and health problems. The following information excerpted from a monthly narrative report is illustrative of some of the counseling required:

> "Personal attention has been given by the project director to innumerable day to day personal life problems of the trainees. It is felt that the number and the character of these problems are directly related to the age group and the income eligibility requirements of the project. Some examples of problems requiring special attention are as follows:
>
> (1) private problems involving trainees' personal emotions; e.g., one trainee was discovered to have a great fear of someone striking her in the home;
>
> (2) situations varying from family problems involving the arrest of a family member to questionable phone calls received by a trainee;
>
> (3) situations requiring personal support; e.g., trainee accompanied to the hospital by project director when her daughter was struck by a car;
>
> (4) clarification of welfare status of individual trainees:
>
> (a) two trainees now do not require financial assistance from welfare sources;
>
> (b) one trainee who had applied for assistance with great reluctance did not require financial help because of income from project, but has had close follow up and was given help in applying for assistance when difficulties were experienced during the first week of the internship phase of the program;
>
> (c) one trainee is receiving some additional financial support from ADC, but does not require the full assistance as she did when she entered the program;

Each of the above situations, and others, required an explanation of the trainee's financial status and payments to trainees under the project in talks with the individual welfare worker. Budget counseling was offered to the individual trainee following such discussion. Clarification to a concerned family member was involved in one case, and follow-up letters and reports were sent to welfare workers assisting several of the trainees.

(5) clarification of social security status of particular trainees:
   (a) in one case this necessitated obtaining a history of earnings from a trainee's previous employer, writing a letter establishing her present earning situation while in training, and having the letter signed with clarification of future social security status by the social security officer for the trainee's record;

(6) budget problems of trainees; e.g., trainees who have had telephones or water shut off;

(7) clinic appointments and special arrangements to assist trainees with health problems:
   (a) a hearing aid for one trainee;
   (b) eye glasses for one trainee;
   (c) serology follow up for several trainees."

The above experiences occurred during the first six-seven weeks of training of the first group and are by no means a complete list of problems encountered. Certain difficulties continued and in some instances were more intense during the internship phase of training. A number of these people whose background was oriented to a day-to-day type of planning have been unable to function on a regular employment basis as well as would be desired. If there is a problem within their home, some are very likely not to show up for work. Some seemed to appreciate the necessity of being in attendance for training more than they subsequently were regular in attendance in the employment situation. Unfortunately, in this particular field, it is in most instances vital that the home health aide be with the patient as scheduled. It is not possible to send another aide in on short notice without orientation from the public health nurse.

It seemed that a higher percentage of problems with drinking, finances and social difficulties; e.g., family member involved with the law, have been encountered with this group than might have been true in a comparable group from a slightly higher socio-economic level. It was difficult to work with those trainees who had the attitude of being able to return to welfare or to try some other training if employment was not arranged to their satisfaction.

The complications of transportation by bus in all kinds of weather and the walking involved is very fatiguing for the older woman. Although her life experience and the "grandmother like" characteristics she brings to the

job are of great importance, in general her work needs to be limited to part-time assignments due to her lack of physical endurance under the fatiguing conditions of getting to the job and traveling between assignments. It would seem that future consideration should also be given to the woman between the ages of 35 and 45. The endurance of the woman of 45 is quite remarkable when compared to that experienced with a woman over 50, in the majority of cases.

In summary, selecting women in the older age group from limited social and economic backgrounds for training as home health aides has merit. Such programs offer possibilities for easing health man-power shortages as well as offering satisfying job roles to individuals who have in the past not been prepared to participate in the work force in a position of dignity. These women can learn simple patient care skills, can be depended upon to carry out their functions responsibly in the patients' home, and can relate ~~approximately~~ APPROPRIATELY to supervisory personnel in relation to patient care needs.

However, those assuming responsibility for training and employing individuals from such backgrounds must be cognizant that:

1. Life habits of these individuals will influence the extent to which they can be expected to meet usually accepted standards of employee responsibility to the employer or job; i.e., personal and home problems may frequently take precedence over the fulfillment of their job attendance responsibility.

2. Such individuals will present need for more counseling and guidance by training personnel and employer than might be true of others from different social and economic backgrounds. They will often develop greater dependence on their employer or supervisor for assistance with solutions of their life problems than will individuals from other groups.

3. Utilizing individuals over the age of forty-five can present some problems relating to their endurance and the physical demands of travel inherent in the health aide role.

C. Project Staff

1. Personnel

The basic staff of the project included a project director, a nurse-instructor, and a clerk-receptionist. Although the project as originally planned did not include a nurse-instructor, the necessity for this additional person became apparent as programming was developed. The project director was a qualified public health nurse with experience in administration and teaching. The nursing instructor was a registered nurse with baccalaureate preparation and seven years' experience in teaching the fundamentals of nursing in addition to hospital administrative experience. The clerk-receptionist was a indigenous worker who was familiar with many of the trainees.

Attachment #1 was developed for orientation of Visiting Nurse Association personnel to the training project and outlines the roles of the professional project persohnel and also the roles and responsibilities of the

staff of the Visiting Nurse Association in this project.

The Visiting Nurse Association's nutritionist, physical therapist, and mental health nursing consultant participated in a teaching and consultant capacity throughout the training program. A medical social worker from Yale-New Haven Medical Center, and a homemaker director from the staff of the local Community Action Program were also utilized as teaching staff.

2. Evaluation of Project Staffing

As noted above, it became evident at a very early point in the project that one person (the project director) could not carry all of the administrative, coordinating, and planning activities as well as the total scope of direct teaching responsibilities required by the project. This problem was shared with the Public Health Service, Office of Economic Opportunity and Community Progress, Inc. (Community Action Program) personnel, and a decision was reached to employ a nurse-instructor. With assistance and direction from the project director, the nurse-instructor carried the primary day-to-day teaching role for personal care procedures during the pre-service phase of the two training periods. This person also assisted with scheduling trainees and aides, with planning the curriculum and, in selected instances, with interviewing of trainees for the second trainee group.

It was fortunate to find a nurse-instructor with experience in teaching basic nursing skills who was willing to work on a part-time basis. Her experience and skill in teaching and her personal ability in working with the trainees was largely responsible for the trainees' development of skills in giving personal care. The most challenging aspect of the program was to encourage excellence in performance without allowing this group of women to become discouraged.

The varied duties of the project director as this particular project was planned were demanding. The day-to-day activities of administering the project, teaching, scheduling, conferring with nurses and aides, and responding to community inquiries left an inadequate amount of time for the reports, designing of evaluation materials, and experimenting with new methods that would have been worthwhile and helpful. A part-time social worker for assistance with interviewing and personal counseling to the trainees would have provided valuable support, or a part-time person primarily responsible for the collection of data and statistics would have made a much more thorough and objective evaluation of the demonstration possible.

The indigenous worker who functioned as clerk-receptionist contributed a great deal to the ease with which the trainees adjusted to their training situation. However, a more highly skilled secretary would have saved innumerable hours of the project director's time by being capable of carrying more responsibility for records, colection of statistical data, etc.

The training program required many nursing hours on the part of the home health agency personnel; the supervisors, and the staff nurses (Hamden, New Haven, and East Haven). Time was consumed in orientation to the home health aide service, evaluation of appropriate home situations for aide assignment, explanation of the service to patients, obtaining doctors' orders, filling out "request for service" forms and new plans for patient care, making telephone contacts in relation to scheduling of home health

aide visits, and then the supervision of the home health aide trainee in the home.

Although not listed as part of project staffing it was anticipated that the executive director of the Visiting Nurse Association of New Haven would be investing time in project development and implementation. Budgeting reports charge off (in non-federal funding categories) the costs of time of the executive director in the amounts anticipated when the project request was submitted. The actual amount of time devoted to the project by the executive director was far in excess of that anticipated and reported.

In summary, it may be stated that: 1. the project would have profited by additional staff (social worker, research person, qualified secretary, and full-time nurse-instructor); 2. the time contributed by the staff of the nursing agencies was far greater than anticipated; and 3. the personality as well as the actual teaching ability and experience of the nurse-instructor should receive careful consideration in project staff recruitment.

D. Training Facilities

1. Description of Training Facilities

An apartment in a large, low-income housing project operated by the New Haven Housing Authority was used as a training center. The unfurnished apartment consisted of one bedroom, a bathroom, a kitchen, and a living room. The project director's desk, two folding tables, and chairs for seventeen people were positioned in the living room. This was used as the prime area for classroom teaching. The bedroom was large enough for only two hospital beds and a table-desk for the nurse-instructor. The secretary's desk was located at one end of the small kitchen area. Front and rear exits required by local fire department regulations were available.

The training center was arranged intentionally to be a setting familiar and comfortable to the low-income people who were to be trained in the project. Informality was encouraged within the training apartment. The trainees provided pictures, seasonal decorations, and plants to give the apartment a home-like atmosphere. They were responsible for the housekeeping of the apartment, and time was allowed at the conclusion of each day for these duties. The concepts of working as a team, of having an organized work plan, and of the preferred methods and equipment to be used in housekeeping were taught very informally. Plans for cleaning equipment and household care were reviewed with the homemaker consultant at the time the training center was furnished to ensure continuity of teaching.

The celebration of a special occasion was encouraged, whether it was a coffee party for a visiting instructor or a holiday party. This provided experience in planning as a group, and an opportunity for the supervisor to observe and informally teach as necessary in kitchen procedures. Such activities also promoted pleasure in the training experience.

By having a training center similar to the actual working situation, much more realistic teaching was possible in regard to the personal care of patients, transfer techniques, and the use of the bathroom facilities.

Routine matters such as where to dispose of bath water and cleaning up after personal care procedures were better demonstrated and practiced than they might have been in a hospital nursing laboratory.

2. Evaluation of Training Facilities

The positive aspects of having a home-like setting with available kitchen and bathroom facilities for teaching and practice are numerous. In addition an atmosphere of informality that could be established because of this setting was beneficial in creating good rapport between instructors and trainees. This initial group experience of inter-racial, professional-non-professional people seemed to be an important factor in the establishment of excellent working relationships. It would also seem that the pleasant experiences offered by the setting had considerable effect on the good attendance record and the lack of drop-outs during training.

The major difficulty in the training facilities was the limitation of space. This may very well have contributed to an exchange of upper-respiratory and viral infections. Adequate demonstration and practice of personal care procedures involving a bed patient might have been accomplished more rapidly if there had been space for more than two hospital beds available.

TRAINING PROGRAM

The training program for each of the two groups consisted of three phases: a pre-service period, an on-the-job period, and an internship or beginning employment period.

A. Pre-service Training Period

This period consisted of four weeks, five days per week (9:00 a.m. to 5:00 p.m. with one-half hour free for lunch). The trainees were paid $1.40 per hour (from project funds) for a 7½ hour day. They were not paid for classes unattended. Instruction started promptly at 9:00 a.m. to encourage good work habits. Attendance was good throughout the four weeks. Comments from group members seemed to correct any tendencies toward tardiness. Neat attire was always noted; this seemed to set a goal toward which all trainees strove. When the question of wearing slacks arose, it was presented to the group along with discussion of training apparel and habits being the same as those for employment. Consequently, the group made the decision against casual clothing.

An important objective during this period was to make the initial training experience pleasurable and satisfying. Many of the trainees entered the program with real concerns about their ability to spend four weeks in training. The trainees had been out of school from thirty to fifty years. They had some questions about being in a learning situation for 150 hours. Some of the efforts toward informality are discussed under "Training Facilities." Other efforts were toward the establishment of informal teaching methods and the careful orientation of all visiting instructors to the background of the trainees and the encouragement of the instructor's informality in presentation. A constant goal was to create a comfortable relationship between the trainees and professional personnel, yet to continue their respect and willingness to follow the direction of the teacher. This objective was considered to be of utmost importance if the home health aide was to work well with the public health nurse and still feel comfortable enough to report all pertinent observations she might make in

a home situation. If the trainee was reluctant to raise questions or to report an observation, her usefulness would be impaired, and the nurse's willingness to include this new person as a member of the home health team would be affected adversely. In general it is believed that the attitude of working with others rather than for them was new to this group.

The primary objectives of this phase of training were to develop competent skills in personal care, to instruct the trainee in nutrition and light housekeeping, and to develop a beginning understanding of patient and family situations, of interpersonal relationships, and the aide's role as a member of the home health team. The primary methods of teaching were demonstration, practice, and discussion (structured and unstructured). When a formal presentation was offered, it was organized primarily around case histories and provided many opportunities for participation by the trainees. Trainees rotated roles as patient and aide to experience the feeling of patient as well as to obtain the practice as aide. Although objections to acting as a patient were presented initially, it was possible to overcome the objections, and the trainees learned to appreciate the value of this experience.

There was no written testing with the exception of recording temperatures, pulse, and respirations to ascertain the trainee's accuracy when practicing. Frequently, the project director would sit down with the group at the conference table with a list of prepared questions and each trainee would reply as her turn arrived. The trainees were receptive to this method and answers given were discussed easily by the group. The project director was able to make an evaluation of the effects of previous teaching. This method also provided an excellent opportunity for re-emphasis of pertinent learnings.

The nurse-instructor was included in these discussions, or conducted further discussions as she felt the need, and she was kept aware of all instruction introduced. Consequently, she was able to reinforce and continue the teaching during actual practice sessions.

The specialists involved in teaching are described under "Project Staff." Outlines of the classes they taught are on file with the Visiting Nurse Association of New Haven and will not be included here because of their length.

Personal care procedures taught are outlined in Attachment #2.

In the last week of the pre-service training period, each trainee accompanied the public health nurse on a total of six to twelve home visits to patient situations in which personal care was being given and home health aide service was indicated. The purpose of these visits was basic orientation to the home situation and an introduction to actual patient care. Upon return to the training setting each trainee was given the opportunity (under the guidance of the project director) to discuss the situations she had observed with the group. This was a profitable and worthwhile experience for each trainee and offered the project director an excellent opportunity for further teaching and clarification of the aide's role.

Evaluation of Pre-service Training Period

The objective of making the basic training experience satisfying was achieved on the basis of the fact that all trainees with one exception completed the pre-service training. The primary objective of teaching new skills and offerin

instruction to prepare the aide as a member of the home health team seemed to be accomplished effectively.

Public health nursing staff who have had continuing experience in supervision and working with the trainees during the internship phases of the program report positively on aide skill in giving personal care to patients. In addition comments by supervisory and nursing staff of the home health agencies involved in the project indicate a keen appreciation of the role the aides are playing in providing more comprehensive care to patients in their homes.

There were longer hours in the pre-service and on-the-job training phases for Group II since no holidays occurred in this period. This made it possible to cover material which was recognized as being helpful during the weekly internship phase conferences of Group I.

One area which possibly should have had more emphasis in the project was the importance of the homemaker function in a home situation where this function is of prime importance and where there is less or no need for personal care. However, at the time of the pre-service training sessions, the use of the home health aide in this capacity was not foreseen. The establishment of a multi-function community homemaker agency and the ultimate decision that the majority of homemaker-home health aides should be employed by that agency made this deficiency apparent.

All trainees were requested to answer evaluative questions and to hand in their unsigned written thoughts on the four week pre-service period. They were unanimous in their conclusions that this was not too long a period and only a few who would have liked a longer time. They were unanimous in their conclusions that all of the material was interesting and worthwhile with the exception of two who felt certain material on light housework was unnecessary. They felt nothing should be deleted for future groups. Such a positive evaluation raises questions. It may be of course partly due to the inability of this group to adequately judge a learning situation and/or to express negative reactions.

The pre-service training period could have been shortened if there had been space for more beds in the apartment which would have allowed for more flexible scheduling of practice opportunities. The personal relationships these women developed during the four weeks and their personal growth and self-awareness must not be overlooked in attempting to evaluate the value of the hours spent in this period.

B. On-The-Job Training Period

This period covered four days each week for two weeks. The home health aides were assigned to carefully selected patient care situations in which, under the supervision of public health nursing staff, they demonstrated their abilities to perform the personal health care needed by the patient. On the fifth day of each week the aides returned to the training apartment for discussion of their experiences in homes and review of any procedures or functions requiring clarification. The trainees were paid $1.40 per hour (from project funds) for time of assignment during these two weeks.

Experience during this period was planned so that it occurred primarily in the homes of patients with whom the aides would be working during the internship period.

Evaluation of On-The-Job Training Period

This was a profitable experience for the trainees and appeared to be of adequate length in view of the supervision and conferences which would continue during the internship period.

The two days devoted to discussions of working within home situations were extremely interesting. Many trainees had selected this field because of "their desire to help others," and, in reality, for the personal satisfactions and sense of importance that they would derive from it. Consequently, there was a great need for sharing of experiences among the trainees. The importance of this need should not be overlooked in future planning. The aides were given ample opportunity for such discussion, under the leadership of the project director, with an opportunity for them to share their concerns openly. Such discussions also presented opportunities for further interpretation of differences to be expected in varying home situations. They also provided a medium for reinforcement of concepts of confidentiality.

The needs of the home health aide for personal recognition must not be overlooked. They need to have their feelings of self-fulfillment and satisfaction reinforced by recognition from others.

C. Internship Period

Formal employment began with the internship period. Aides were paid at an hourly rate of $1.50 per hour by the employing agency. During this period a group conference was held one afternoon a week for all trainees and was paid for from project funds.

Conferences were led by the project director. Other instructors contributed to these conferences as a need for review or the presentation of new material in their particular field became apparent; i.e., with both groups a session with the physical therapist devoted to review of transfer techniques and problems met in individual situations seemed needed and proved worthwhile. A first-aid course was offered by a qualified Red Cross instructor. Individual conferences as requested by the aide or when the need became apparent to the project director were arranged also at this time. Each aide was offered personal recognition and individual consideration during this afternoon session. The weekly conference was felt to be very important for continuity of training into actual employment.

It was interesting that an enormous amount of sharing of information about their experiences in home situations was needed during conferences in the early weeks of this period. As the aide's confidence and awareness of her new role developed, the need decreased markedly.

Staff nurses active in individual patient situations continued to supervise the aides on a regular basis, orienting them to changing patient situations, demonstrating personal care tasks which might need clarification, etc. All aides were assigned to patients in accordance with a plan of treatment established and regularly reviewed by the patient's physician.

Aides were given individual assistance in increasing their knowledge and understanding of patient care needs through guidance related to specific patient care situations in which they were involved. For example, the physical thera-

pist might visit in a home with an aide to demonstrate range of motion exercises for a specific patient. Another example would be a conference arranged by the nursing supervisor, the staff nurse, and the home health aide for the purpose of sharing observations to better evaluate a home and patient situation.

Evaluation of Internship Period

The aides' performance in general was good. The majority had a marked preference for situations involving a maximum of personal care. Considerable time was spent in clarifying the limits of light housekeeping to both the home health aides and recipients of service. The demanding attitudes of families in some situations were difficult for the aides to adjust to and to cope with.

The weekly conferences were of great value. It is felt that some such conferences, possibly on a monthly basis, would be extremely profitable during continuing employment. The aide's desire for on-going educational opportunities and an opportunity for advancement seems very important to her continued growth in the role of homemaker-home health aide.

EMPLOYMENT

Three home health agencies in the Greater New Haven area, certified under the Medicare program and the Homemaker Services Bureau of Greater New Haven, employed the aides during the internship period of the project. The number of aides trained (30) was based on the stated ability of the employing agencies to fully utilize that number prior to the initiation of the project. Communication and cooperation between the supervisors of each employing agency and the project director was excellent at all times. There was a highly profitable exchange of ideas and plans in establishing this new service, evaluating the training program, and in solving problems which occurred; i.e., priorities for service, evaluation of appropriate home situations, reactions of the trainee, etc.

When the project was originally conceived, the Homemaker Services Bureau of Greater New Haven was in the process of development but had not been organized or staffed. Planning for internship and continuing employment of the trainees as outlined in the project indicated that the thirty aides to be trained would be placed as follows:

East Haven Public Health Nursing Association	- 2
Hamden Public Health and VNA	- 3
Homemaker Services Bureau	- 7
Visiting Nurse Association of New Haven	- 18

A. Group I

Since the Homemaker Services Bureau was not in existence, trainees who entered the internship phase on January 3, 1967 were all assigned to the nursing agencies. Assignments were as follows:

East Haven Public Health Nursing Association	- 1
Hamden Public Health and VNA	- 2
Visiting Nurse Association of New Haven	- 11

During February and March 1967, the Homemaker Services Bureau came into being. It was anticipated that this agency would be ready to employ staff and offer service by April 1, 1967.

At the request of the Homemaker Services Bureau board the question of the feasibility and desirability of all home health aide service emanating from the homemaking agency was considered by a joint committee of the New Haven Visiting Nurse Association board and the Homemaker Services board during March 1967. After much deliberation, it was decided that the best interests of the public and the aides as well would be served if the suggested plan was adopted. The Visiting Nurse Association of New Haven, and subsequently the Hamden Public Health and Visiting Nurse Association reserved the right to retain a limited number of aides for full-time appointment to their agency staff.

Therefore, 9 aides of Group II who were ready for entering the internship period on April 1, were assigned to the Homemaker Services Bureau, and 1 aide from Group I was transferred from the New Haven VNA to the homemaker agency on that date. The remaining 5 trainees of Group II were assigned to the nursing agencies to begin their internship period.

At the beginning of succeeding months through August 1, 1967 additional trainees and aides were transferred to the homemaking agency with the exception of the three aides retained by the Visiting Nurse Association of New Haven and appointed as full-time public health aides and the two aides who were kept by the Hamden nursing agency as their employees. The East Haven Public Health Nursing Association discontinued their corporate status as of July 1, 1967 and merged services with the Visiting Nurse Association of New Haven. Aides and trainees formerly assigned to that agency were transferred to the homemaker agency.

CAREER ADVANCEMENT

Three aides were chosen from Group I to serve as preceptors to trainees in Group II. One of these aides was available part time to assist with the practice of personal care procedures for one week of the training session. The other two aides presented case histories of patients they were caring for from a simple outline devised for this purpose. These presentations followed by discussion were given as an additional method of interpreting and clarifying the aide role. The aides were paid $1.60 per hour for time spent in the preceptor role. This was a profitable experience for the aides, the trainees, and was of assistance in teaching. The availability of home health aides for use as preceptors in the training program was complicated by the fact that they were fully scheduled for home assignments in patient care during this period. The success of using aides in this capacity indicates that they could be used more extensively as preceptors in future training sessions.

The aides who functioned as preceptors have indicated interest in becoming licensed practical nurses and might do well in this capacity. However, LPN training programs do not accept women over fifty years of age, and the interested candidates from this project would not be acceptable because of their age.

Three home health aides were identified for employment as public health aides by the Visiting Nurse Association of New Haven. They are providing personal health care service on a basis similar to the short-term visits made to patients at home by nursing staff. These visits occur in between regular visits of nursing staff and

consist of duties appropriate for the home health aide to carry. The public health aide may also assist in child health conferences and in the bag packing and supply area of the Visiting Nurse Association. The activities assigned to the public health aides are those that they can carry out under supervision. Such assignments relieve nursing staff so that they can provide service requiring professional skill. The public health aides are employed on a salaried basis with vacation, health, and insurance benefits comparable to other staff members of the Visiting Nurse Association. At this time a formal program of advanced training has not proved necessary for this position. On-the-job training for new experiences; e.g., child health conferences, has been provided by the public health nurse or other appropriate supervisory personnel.

Plans are being formulated for a training program to be held in the fall in conjunction with the Connecticut Mental Health Center. Five home health aides now employed by the Homemaker Services Bureau are to be trained to function in situations where there is psychiatric illness.

PLANNING AND ADVISORY COMMITTEE

This committee consisted of nine members with the executive director of the Visiting Nurse Association, the project director, and a Community Council representative functioning in an ex-officio capacity. The committee included one member from the boards of each of the employing agencies (4), a representative from the New Haven Council of Senior Citizens, a home health aide trainee, a representative from the Resident Advisory Committee to the local C.A.P., a representative of the Community Council Committee on Aging, and a physician. Committee meetings were used primarily for sharing of the problems and concerns of the employing agencies, and for keeping the committee informed of project activities. Committee members indicated that they were comfortable with having the VNA of New Haven establish the criteria and planning for training and handling the financing of the project because of this agency's professional experience. These plans were always presented to the committee for their evaluation and suggestions.

There were problems in using the committee as fully as might be desired in the planning for the training. Time was a major problem. It took considerable time to identify the five people, in addition to those from the employing agencies, who would be willing to serve on the committee. It was then necessary to establish a meeting date far enough in advance to allow the participants an opportunity to fit it into their schedules. Meanwhile, it was essential to start the training program for Group I.

The Board of Directors, the Medical Advisory Committee, and the Home Health Agency Professional Advisory Committee of the Visiting Nurse Association of New Haven were actively involved in the project. These groups were presented with regular progress reports on the project. The Medical Advisory Committee reviewed and approved policies developed by the agency in relation to the home health aide service program, the role of the aides, professional nursing staff, etc.

Evaluation of Planning and Advisory Committee

The Planning and Advisory Committee was extremely useful for the purpose of community education and for sharing of information among the employing agencies. Because of the involvement of other VNA committees (Home Health Agency Professional Advisory and Medical Advisory) the Project Advisory Committee did not become involved in setting policy. Had there been some way to include the committee prior

to recruitment and training, they might have been more actively involved and been used more effectively.

Because of the many commitments a physician may have, the medical representative was very difficult to identify when planning the advisory committee. Although meetings were planned to suit the convenience of the practicing physician who did agree to serve and although he was interested and willing to be of assistance, he was not available for any meetings. In view of the involvement of the Medical Advisory Committee of the VNA, the lack of active participation by the physician member of the Project Advisory Committee, while regretful, was not handicapping to the project.

VALUE OF PRE-VOCATIONAL TRAINING PROGRAM

The trainees prepared at the C.A.P.'s Skill Center have performed above average in employment as home health aides. The advantages of these programs to the trainee can best be summarized by example.

Mrs. X was recommended to the project after spending several months of prevocational training at the Skill Center. She proved to be an exceptionally reliable worker. When this fact was shared with the Skill Center director, she indicated the trainee previously had been unable to maintain employment and had difficulty with continuous class attendance due to her frequent complaints of illness and trips to clinic and doctors' offices. It seemed very apparent that the woman's Skill Center training plus the satisfaction she was receiving from her new experiences as a home health aide had markedly improved her work habits.

Mrs. Y spent eight months at the Skill Center prior to entering this training. Her educational background was limited. Her prior work experience was as a domestic. This woman has been one of the three trainees to be advanced to the position of public health aide and a regular salaried member of the staff of the Visiting Nurse Association of New Haven.

CONCLUSIONS

An attempt has been made in this report to summarize the means by which the five objectives of the project as described on pages 1 and 2 have been fulfilled. A beginning has been made in meeting a specific need for home health aide service in the Greater New Haven community by a well-trained group of people who previously had limited employment potential. The opportunity to offer a training program adequate in time and content to set a high standard for future home health aides was appreciated.

In general the aides that have been trained are giving excellent care to homebound ill patients in great need of such service. The major problems being encountered are those of individual personality and adjustment to responsible work habits. Attitudes expecting complete job satisfaction at all times are unrealistic and difficult with which to work. Personalities and attitudes are not changed in four weeks or four months. The habits of a day-to-day existence are difficult to change. The feelings that one rises above a domestic level by refusing to do domestic chores are hard to counteract.

Certainly this has been a profitable experience for all concerned. There are

without question women with limited incomes and background, over forty-five years of age who can be trained as home health aides. However, regardless of training efforts, it is largely the personality, warmth and interest in caring for others that an individual brings with them to the training, that is responsibile for their ultimate success in the role of a home health aide.

Attachment I

THE VISITING NURSE ASSOCIATION OF NEW HAVEN

HOME HEALTH AIDE SERVICE PROGRAM

I. Scope of Program

Home health aide services are designed to offer personal health care to patients in their homes when selected needs of the patient can be met by the assignment of an aide who has been trained to provide specific, non-professional care services.

II. Provision of Service

Home health aide service is provided to patients under the care of the Visiting Nurse Association through the assignment of its own workers, public health aides, or through contractual arrangements with the Homemaker Services Bureau of New Haven and the Milford Homemaker Service. In these latter agencies the assigned worker is referred to as a Home Health Aide.

III. Definition of Home Health Aide and Public Health Aide

The home health aide is a non-professional person assigned to give assistance to the patient in the home where there is a health problem. The aide is oriented to patient care situations, supervised, and evaluated regarding performance of patient care tasks by the professional nursing staff of the Visiting Nurse Association.

Each aide is oriented to each new assignment by the professional nurse so that the application of her (aide) skills are individualized to meet the needs of the particular patient. Supervision of the total patient care situation is the responsibility of the professional nurse who in turn delegates appropriate patient care tasks to the aide.

IV. Range of Duties of Aides

A. General range of tasks which the aide may be assigned to carry out:

1. Patient Care Procedures -

a. Assist patient in and out of bed.
b. Assist with transfer from bed to chair, chair to commode and return.
c. Assist patient with bed bath or with sponge bath out of bed, or, upon specific physician orders, with tub bath or shower.
d. Assist patient with care of hair, teeth, fingernails.
e. Rub patient's back.
f. Assist patient with use of bedpan and urinal.
g. Assist patient with dressing and undressing.
h. Encourage active exercise when appropriate and help patient to use special equipment, such as walker or wheelchair.
i. Assist patient with taking oral medications prescribed by the physician; i.e., bring to patient the prescribed medicines.
j. Assist in promoting mental alertness of patient through conversation and participation in games and other appropriate activities.

2. Other Tasks -

a. Prepare nutritious meals, serve meals and assist with feeding, if necessary.
b. Change bed linen and perform light household chores; e.g. dishes, dusting, light personal laundry.
c. Do necessary shopping - groceries, drug needs, minor clothing items.
d. Assist and accompany patient with trip out of doors in appropriate weather.
e. Assist and accompany patient in visit to physician or clinic.
f. Keep simple records and record messages.
g. Assist in other ways which may be determined as appropriate by the professional nurse.

V. Roles of Staff Involved in Patient Care

A. Role of Home Health or Public Health Aide

1. Under the guidance and direction of the professional nurse, the aide will:

a. provide personal health care to the patient as directed and planned by the nurse.
b. assist with designated household duties to maintain a healthful environment.
c. accompany the patient on essential trips and/or do necessary errands.
d. keep simple records and record messages.
e. participate in conversation and appropriate activities which will promote mental alertness of the patient.
f. observe any deviations from usual physical or mental status of the patient and report the fact to the professional nurse.
g. inform the professional nurse of significant needs or changes in the home situation.

B. Role of Professional Nurse

1. The professional nurse is responsible for guiding and supervising the aide and for supervising the patient's care.

a. In all situations she will:

(1) select patient care situations appropriate for assignment of home health or public health aide.
(2) secure physician's written orders for aide service.
(3) explore with family placement of an aide, interpret services and, if this plan is acceptable to family, establish arrangements for service.
(4) complete the patient referral form and activities sheet for the aide.
(5) orient the aide to the particular home situation and to her specific duties, including demonstration of patient care tasks to be performed by the aide.

(6) plan for regular opportunities for discussion between the aide and herself regarding needs of the patient and family. When appropriate, the nursing supervisor will be included in such communication.
(7) develop a plan for a specific schedule for visiting the home to observe the aide functioning in her job and for supervision of the total patient care plan.
(8) periodically review the patient care situation. Factors considered in review are:

(a) need for continuation of aide service.
(b) plan for securing renewal of written orders.
(c) duties of aide.
(d) hours aide will be needed.
(e) satisfaction of family, patient, aide and nursing service with the plan for patient's care as it involves aide service.

(9) assist in evaluating the aide in relation to performance of patient care tasks.
(10) keep the supervisor informed of changes or problems in the situation.

b. In addition, in situations involving homemaker-home health aide agencies she will:

(1) evaluate patient care situations on request from the homemaker agency to determine appropriateness of assignment of home health aide.
(2) communicate with homemaker agency regarding needs for aide service (frequency of assignment, hours, etc. as well as needs in the patient care situation) in response to their request in (1) above.
(3) communicate with homemaker agency requesting assignment of a home health aide when need for such is initially identified by nursing service.

c. In situations involving assignment of public health aide from the Visiting Nurse Association she will:

(1) in addition to following general procedures (as in (1) and (2) above), make appropriate plans for payment for service.

C. Role of VNA Supervisor

1. The VNA supervisor is responsible for service offered by the agency. In this capacity she will:

a. plan with staff and homemaker services personnel for providing patient care evaluations and for assignment of aides.
b. assume ultimate responsibility for functioning and evaluation of aides in relation to performance of patient care tasks by aides working under the direction of nurses in her division.

VI. Guidlines for Determining Priorities for Assignment of Aides

A. Priorities will be given in the following situations:

1. When there is a patient who has potential for becoming self-sufficient in meeting his own needs.

2. When there is a patient living alone all or part of the day who needs assistance with personal care and housekeeping to enable him to remain safely in his home and thus delay or prevent hospitalization.

3. When a patient with needs similar to 2. above is living with spouse or other family member who is unable to meet the personal health care needs of the patient.

4. When there is a need for temporary relief for a family with a patient who has a chronic illness.

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December 1967

ATTACHMENT II

THE VISITING NURSE ASSOCIATION OF NEW HAVEN
HOME HEALTH AIDE TRAINING PROJECT

Personal Care Procedures Taught
During Pre-service Training Period

1. Self-grooming
2. Body mechanics
3. Apron Technique
4. Hand washing
5. Making an occupied bed
6. Making an unoccupied bed
7. Setting up a personal care tray
8. Bed bath
9. Sponge bath
10. Tub Bath
11. Shower
12. Care of mouth
13. Care of dentures
14. Care of finger nails
15. Care of toe nails (with limitations-not to be done for selected patients)
16. Care of hands
17. Care of back
18. Care of feet
19. Care of skin
20. Care of hair
21. Shampoo
22. Dressing and undressing the patient
23. Feeding the patient
24. Shaving the patient - During On-The-Job and Internship when appropriate
25. Use and care of bedpan
26. Use and care of urinal
27. Use and care of commode
28. Temperature and care of thermometer
29. Pulse
30. Respiration
31. Positioning of patient in bed
32. Range of motion
33. Transfer from bed to chair
34. Transfer from bed to wheel chair
35. Transfer from chair to wheel chair
36. Transfer from chair to bed
37. Transfer from wheel chair to bed
38. Assisting patient in and out of tub
39. Assisting patient to walk
40. Assisting patient to ambulate with crutches
41. Assisting patient to ambulate with walker

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42. Assisting patient to ambulate with cane

43. Assisting patient to walk up and down stairs

44. Improvisations

    a. applicators

    b. back rest

    c. bed tray

    d. bed cradle

    e. urinal

    f. bed table

    g. bed call bells

    h. foot board

    i. paper slippers

    j. bathrobes

    k. bed jackets

45. Assisting with oral medication

46. Care of medicines

47. Application of ace bandage or elastic stocking

48. Draping the patient

49. Simple dressings-bandaging and dressings requiring clean but not sterile technique

50. Care of drainage bags or bottles

51. Care of decubitus

52. Use and care of hot water bottles

53. Use and care of ice bag

54. Hot packs

55. Cold packs

56. Throat inspection

57. Dressing the child

58. Feeding the child

59. Care of food

60. Preparation of meals

61. Preparation of special diets

62. Tray setting

63. Dishwashing

64. Care of soiled laundry

65. Storage of clean linen

66. Use of household appliances

    a. washer

    b. dryer

    c. gas stove

    d. other appliances

67. First aid

    a. care of lacerations, cuts and bruises

    b. care of bleeding

    c. care of fractures

    d. care of burns

    e. treatment of shock

    f. treatment of fainting

    g. artificial respiration

68. Keeping records and reports

69. Recording intake

70. Recording output

71. Telephone courtesy